



## PATIENT REGISTRATION

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_ S.S.N. \_\_\_\_\_  
First Name Last Name MI Preferred Name

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Are you:  Minor  Single  Married  Separated  Divorced

Spouse or Parent's Name: \_\_\_\_\_

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referred to our office by: \_\_\_\_\_

Dental Insurance: \_\_\_\_\_  
Name Policy Holder Name & SSN Group#

Emergency Contact: \_\_\_\_\_  
Name Address Home Phone Work Phone

Physician: \_\_\_\_\_

## RESPONSIBLE PARTY

Name of person responsible for this account: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_



## MEDICAL HISTORY

Describe your general medical health     Excellent     Good     Fair     Poor

Are you currently under the regular care of a physician?     Yes     No

Have you ever been hospitalized or had an operation?     Yes     No

Do you have any problems with anesthesia, General or Local?     Yes     No

Have you ever taken Recreational Drugs?     Yes     No

Have you ever taken Podimin, Redux or Fen-Phen?     Yes     No

Are you sensitive or allergic to any medications?     Yes     No

- Penicillin     Aspirin     Local anesthetic     Codeine     Latex \_\_\_\_\_  
 Motrin/Ibuprofen     Other \_\_\_\_\_

Have you ever had skin reaction to metals in jewelry?     Yes     No

Do you smoke?     Yes     No    If Yes, How Much?

Women: Do you take oral contraceptives?     Yes     No

Are you pregnant or breastfeeding?     Yes     No

Check any of the following which you currently have, or have had

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Heart Lesions          | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Arthritis        |
| <input type="checkbox"/> Cardiac Pacemaker      | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Hepatitis/Jaundice    | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Heart Murmur           | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Rheumatic Fever  |
| <input type="checkbox"/> Mitral Valve Prolapsed | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Anemia                | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Sinus Trouble       | <input type="checkbox"/> AIDS/ARC/HIV Positive | <input type="checkbox"/> Tumors           |

Have you had any other serious illness?     Yes     No

Please list the name of all your current Medications:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_



## DENTAL HISTORY

When was your last dental visit? \_\_\_\_\_ What was done? \_\_\_\_\_

How would you describe your dental health?  Excellent  Good  Fair  Poor

Do you have a problem with any of the following?

- |   |  |
|---|--|
| <input type="checkbox"/> Teeth sensitive to hot     | <input type="checkbox"/> Receding gums                     |
| <input type="checkbox"/> Teeth sensitive to cold    | <input type="checkbox"/> Sore Gums                         |
| <input type="checkbox"/> Teeth sensitive to sweets  | <input type="checkbox"/> Bleeding gums                     |
| <input type="checkbox"/> Teeth sensitive to chewing | <input type="checkbox"/> Frequent cold sores/ canker sores |

Do you grind/clench your teeth?  No  Yes, but I don't think it's causing any problems  
 Yes, and I think it may be causing Problems

Do you feel like you still get a lot of cavities?  No  Yes, but I probably wouldn't do home care  
 Yes, and I may consider home care

Do you frequently get bad breath?  No  Yes, but I can usually fix it myself  
 Yes, and I would like to discuss treatments

Check any of the following that you have had:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Gum Treatment | <input type="checkbox"/> Wisdom teeth removed |
| <input type="checkbox"/> TMJ Treatment         | <input type="checkbox"/> Root Canals   | <input type="checkbox"/> Bridges/Partials     |

Is there any old dentistry you want replaced?  Yes  No

How well do you clean your teeth and gums?  Excellent  Good  Fair  Poor

How often do you Brush? \_\_\_\_\_ Floss? \_\_\_\_\_

Do your gums bleed?  Never  Occasionally  Frequently  
 Every time I brush  Only when I floss



What phrase best describes how you feel about losing your teeth?

- It doesn't bother me
- I thought everyone did eventually
- I'll do my best to prevent it
- I'd do anything to save my teeth

How do you rate your smile on a 1-10 scale?

Unhappy 1 2 3 4 5 6 7 8 9 10 Very Happy

What best describes how you feel about your smile?

- Satisfied
- If it could be improved easily and inexpensively, I might consider
- I'd do anything to improve my smile

If looking for some improvement, is it for:

- Color
- Chips
- Spaces
- Crooked teeth
- Shape/ size
- Other \_\_\_\_\_

In general, how do you view dental treatment?

- I'm fairly relaxed about it
- It makes me a little uneasy
- It makes me tense
- It makes me very anxious

Anything else we should know about? \_\_\_\_\_

What dental services are you expecting at today's visit? \_\_\_\_\_



## FINANCIAL AGREEMENT

As the patient (or legal guardian), I verify that the responses listed above are true and complete, and authorize Dr. Elham Safari and staff to perform professional dental services.

I understand and agree that the payment of my bill is my obligation. All filings of insurance papers and confirmation of eligibility of benefits and/or confirmation of insurance payments to be made by any insurance company are my responsibility. Any assistance in this matter granted by the above doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part of filing, follow-through or confirmations. I understand that all insurance co-payments are collected in advance and Treatment Plans are only estimates of treatment and cost. The insurance company makes the final determination of payment when they process the claim.

In the case that my account should become delinquent and is placed in the hands of an attorney for collections, I agree to pay attorney fees of 35 percent of the principal and interest balance owing, plus all courts cost, late charges, and finance charges at the rate of 1.5% per month (18% per annum) to any balance owed 60 days after services are rendered. I further agree to pay returned check charges of \$25 per returned check.

## Cancellations and Missed Appointments

Broken appointments are not fair to any parties involved. They deny other patients the use of time they cost the practice money as staff salaries and other expenses continue. They make our office hesitant to appoint that patient again. Our practice does not profit from these charges. We merely cover expenses incurred by broken appointments, we charge \$45 per half an hour.

These charges are assessed to patients that have not given our office **48 hours** "business day" notice. By your signature, it is understood and agreed that you are directly responsible for the payment.

Patient Name \_\_\_\_\_

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_